# Medicare Mental Health Workforce Coalition

September 8, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1784-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

**Re: CMS-1784-P: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program**

Dear Administrator Brooks-LaSure:

The undersigned behavioral health and patient groups are members of the Medicare Mental Health Workforce Coalition. Our coalition is comprised of national and state organizations collectively representing hundreds of thousands of mental health and addiction disorder providers, patients, families of patients, payers and other stakeholders in the mental health provider system. We provide the feedback set forth in this letter regarding the proposed regulations to implement Medicare payment under Medicare Part B for services provided by licensed marriage and family therapists ("MFTs") and licensed mental health counselors ("MHCs").

Members of the Coalition have reviewed the proposed rule as it pertains to the inclusion of MFTs and MHCs as Medicare providers. We would like to thank CMS for proposing these important changes. While the Coalition is pleased in general with the proposed rules, we would like to point out several issues for additional consideration.

**Clinically Supervised Experience**

Under Section 4121 of the Consolidated Appropriations Act ("CAA"), 2023, both an MFT and an MHC are defined as someone who, among other requirements, has "performed at least 2 years of clinical supervised experience" after obtaining the applicable master's or doctor's degree qualifying for licensure. Under Section II.J of the Medicare Physician Fee Schedule ("MPFS"), it states that CMS is proposing to define marriage and family therapist in 42 C.F.R. 410.53 of the

proposed rule and to define mental health counselor in 42 C.F.R. 410.54 of the proposed rule to require that these providers, among other requirements, have "performed at least two years or 3,000 hours of post master's degree clinical supervised experience" after obtaining the applicable degree.

In the comments under Section II.J, CMS indicates that it is possible that some MFTs and MHCs may have completed the required number of clinical supervised hours required for licensure in their state, but completed these hours in less than two years. We agree that it is possible for an MHC or MFT to complete the required number of clinical supervised hours required for licensure in their state in less than two years. Therefore, CMS is proposing a requirement that an MHC or MFT must have performed at least two years or 3,000 hours of post master's degree clinical supervised experience.

For applicants who obtained this supervised clinical experience in less than two years, we appreciate that CMS is proposing that MFTs and MHCs may also meet this requirement by having performed at least 3,000 hours of post master's degree clinical supervised experience. We support this proposed language. However, even with this additional flexibility, **we believe that there would be some MHCs and MFTs who may not meet the supervised experience standard as specified in the proposed rule**. For example, the licensure laws for MFTs in seven states do not specifically state that that an MFT must have at least two years or 3,000 hours of post master's degree clinical supervised experience.[1] In recent years, some states have amended their licensure laws to permit MFTs and MHCs to count some supervised clinical experience obtained pre-degree towards the minimum number of hours or years of supervised experience required for licensure.[2] In addition, several states also allow applicants for licensure with a doctoral degree in marriage and family therapy or mental health counseling to have performed less than two years of clinical supervised experience and less than 3,000 hours of supervised experience. Although most licensed and practicing MHCs and MFTs would meet the clinical supervised experience requirement as proposed, some providers will not. In particular, those providers who have obtained their supervised experience in a community mental health setting are more likely to accumulate the required number of hours of experience in less than two years. This provider group, a group likely to enroll as Medicare providers, should not be rendered ineligible to participate as Medicare providers if there is another way to establish their eligibility.

[1] The MFT licensure laws in Alaska, Connecticut, Michigan, New York, North Carolina, South Dakota and Virginia do not specifically require that applicants for licensure as a MFT must have obtained at least 2 years of clinical supervised experience or 3,000 hours of clinical supervised experience. This does not mean that all licensees in this state had less than 2 years or 3,000 hours of clinical supervised experience, as it appears that many MFTs in those states did obtain at least 2 years or 3,000 hours of clinical supervised experience. The laws in these states do not specifically require at least 2 years or 3,000 hours of supervised experience.

[2] For example, under California law, up to 1,300 hours of the 3,000 hours of clinical supervised experience can be obtained prior to the awarding of a degree. See Cal. Bus. & Prof. Code 4980.43.

Regarding the supervised clinical experience requirement, **we have several items for consideration**:

As a threshold matter, is the clinical supervised experience requirement in proposed rules 42 C.F.R. 410.53(a) and 410.54(a), based upon whether each MHC or MFT performed at least two years or 3,000 hours of post master's degree clinical supervised experience? Or, is the clinical supervised experience requirement based upon the licensure requirements of the state where the licensee was initially licensed? For example, would an MFT or MHC who had performed at least two years or 3,000 hours of post master's degree clinical supervised experience meet this requirement even though the law in state where they were initially licensed required less than two years of clinical supervised experience and less than 3,000 hours of post master's degree clinical supervised experience? The text of the proposed rule and Section 4121 of the CAA, as well as the related text pertaining to the existing mental health professions recognized by Medicare, would indicate that it is an individual's actual experience that would matter, not the specific requirements outlined in state law. We ask that CMS confirm this interpretation.

Proposed rules 42 C.F.R. 410.53(a)(2) and 410.54(a)(2) and Section 4121 of the CAA, state that MFTs and MHCs must have the applicable clinical supervised experience. The phrase "clinical supervised experience" is not defined in the MPFS proposed rule. This phrase is also not defined in Medicare's current laws or policies. Like other healthcare providers, many MHCs and MFTs work under a supervisor even after receiving a license as specified under 42 C.F.R. 410.53(a)(3) and 410.54(a)(3). For those MHCs and MFTs who may not have performed at least two years or 3,000 hours of post master's degree clinical supervised experience prior to obtaining a license, we believe that such experience earned after obtaining a license should count towards fulfilling the requirements under 42 C.F.R. 410.53(a(2) and §410.54(a(2). Many mental health professionals continue to work under clinical supervision even after obtaining licensure. For those MHCs and MFTs who may not have performed at least two years or 3,000 hours of post master's degree clinical supervised experience prior to obtaining a license, **we urge CMS to allow these applicants to count such supervised experience obtained after receiving their license, along with the experience earned prior to receiving their license, as meeting the clinical supervised experience under 42 C.F.R. 410.53(a)(2) and 410.54(a)(2).**

Again, we appreciate the option of allowing applicants to have performed at least 3,000 hours of post-master's degree clinical supervised experience in place of at least two years of experience. In many states, applicants for licensure must have supervised experience known as direct client contact or direct counseling with individuals, families or groups.[3] This type of experience must be gained by working directly with clients. Other clinical activities not considered direct client contact do not count towards these hours. In many states,[4] direct client contact hours are a subset of the total number of hours of clinical supervised experience

[3] For example, under New York law, an MFT is required to have a minimum of 1,500 hours of clinical supervised experience, all of which must consist of direct contact with clients.

[4] For example, under Illinois law, an MFT is required to have 3,000 hours of clinical supervised experience. Of this experience, at least 1,000 hours must be face-to-face client contact.

required for licensure, typically about one-third of the total amount of clinical supervised experience that is required. In addition to the requirement that MFTs and MHCs have at least two years or 3,000 hours of post master's degree clinical supervised experience, **we encourage CMS to consider allowing applicants who may not have performed at least two years or 3,000 hours of post master's degree clinical supervised experience before becoming licensed but who instead provided an equivalent number of hours of direct client contact experience to meet the supervised experience requirements.** The 1,000 hours of direct client contact is roughly equivalent to the two current options under 42 C.F.R. 410.53(a)(2) and 410.54(a)(2) and would ensure that the applicants have the necessary supervised experience.

**Enrollment Issues for MFTs and MHCs**

We appreciate the implementation guidance provided by CMS in the proposed rule clarifying that MFTs and MHCs may begin submitting enrollment applications as soon as the MPFS rule is finalized. Attention to the practical details of enrollment during this time of transition is appreciated.

Current CMS regulations (42 C.F.R. 424.510(d)(2)(iii)) specify the documentation that suppliers are required to provide during the enrollment process. As MFTs and MHCs become eligible to enroll in the Medicare program we expect that some suppliers who have been in practice for quite some time, even decades, may want to enroll. However, before now these providers have had no reason to keep documentation or any other kind of proof of clinical supervision after initial licensure. There is currently no central repository for clinical supervision documentation. It is also highly likely, for reasons such as death, retirement, relocation, etc., that it would be difficult, if not impossible, for some previous supervisors to verify clinically supervised experience for licensees. For MFTs and MHCs who are enrolling in the Medicare program for the first time, **we ask CMS to consider accepting an attestation as evidence of having met the clinically supervised experience requirement** and that the regulations be modified to so provide. After the initial group of MFTs and MHCs are enrolled in Medicare, subsequent MFTs and MHCs will be on notice that they will need to keep this documentation for enrollment purposes. Respectfully, **we request that CMS implement modifications to the provider enrollment regulations to provide flexibility for newly-enrolling MFTs and MHCs on documenting this supervised experience**.

Lastly, we acknowledge that some MFTs and MHCs have been providing services to Medicare beneficiaries before they were eligible to receive Medicare reimbursement. In situations where the beneficiary has dual health coverage and Medicare is the primary payor, the secondary payor will not pay the claim unless the practitioner can obtain a claim denial from Medicare. It has not been possible for MFTs and MHCs to secure this denial without being enrolled in the Medicare program. We ask CMS to issue claims denials for services provided during 2023 to Medicare beneficiaries so that the practitioners can pursue secondary payment.

**Hospice Interdisciplinary Groups**

We thank CMS for proposing to include MFTs and MHCs as eligible to serve on the hospice interdisciplinary group (IDG). We agree with the comments in the MPFS that both MHCs and MFTs bring unique supports and services that will be beneficial to many hospice patients and their families.

MHCs and MFTs are proposed to be included in 42 C.F.R. 418.56 as part of the IDG, and listed in 42 C.F.R. 418.114 pertaining to personnel qualifications. However, we believe some changes to 42 C.F.R. Part 418 are needed to ensure that MFTs and MHCs can effectively serve as hospice providers. MHCs and MFTs are added as non-licensed personnel under 42 C.F.R. 418.114(c), but MFTs and MHCs do not fall within this definition. Section 418.114(c) appears to apply to professions that are not licensed, certified or registered under state law. We believe that this is the incorrect subsection for the inclusion of MFTs and MHCs. Instead, these professions should be listed under 42 C.F.R. 418.114(a). In addition, MFTs and MHCs appear to be missing from several other applicable rules. For example, MHCs and MFTs are not listed as medical social service providers as social workers are in 42 C.F.R. 418.64 and also referenced in 42 C.F.R. 418.202.

Under the CAA, the language regarding inclusion of MFTs and MHCs in hospice IDGs states that IDGs should **"at least"** include a Social Worker, MHC or MFT. We seek clarification on this provision in the final rule that the IDG can include both a SW and MFT, or a SW and MHC – not just one provider. In the proposed rule, CMS describes the unique roles these providers can play in addressing the needs of the patient, and that the patient and family should have an opportunity to tap into all the incredibly important expertise available during the hospice process. We seek clarifying language on this provision.

**OMISSIONS FROM 2024 MPFS**

We noticed that there are several omissions by CMS in incorporating MFTs and MHCs fully into the Medicare program, and request that CMS consider additional regulations as set forth below.

Private Contracts

CMS did not propose to add MFTs and MHCs to the definition of "practitioner" in 42 C.F.R. 400.400 which would enable MFTs and MHCs to opt out of the Medicare program and make use of private contracts with Medicare beneficiaries. We know of no reason that MFTs and MHCs should not be included here, and **we request that CMS enact a regulation to provide the benefits of these regulations to these practitioners**.

Conforming Changes to Physician Self-Referral Exception

42 C.F.R. 411.357 provides for certain exceptions to the federal Physician Self-Referral Law, or Stark Law. One such exception is for certain assistance paid by a hospital to a physician to compensate a nonphysician. **We ask that CMS amend 42 C.F.R. 411.357(x)(3), so that the definition of "non-physician practitioner" is expanded to include MFTs and MHCs to allow these practitioners to enjoy the same privileges as other mental health practitioners**.

Use of ICD-9-CM

The regulation setting forth "basic requirements for all claims" under the Medicare program as set forth in 42 C.F.R. 424.32(a)(2) should be amended to include claims for MFTs and MHCs to confirm the coding requirements for these practitioners, identical to those that apply to social workers.

Therapeutic Outpatient Hospital or CAH Services and Supplies Incident to a Physician's or Nonphysician Practitioner's Service

Medicare Part B pays for certain hospital services furnished incident to a physician or nonphysician practitioner's service. While 42 C.F.R. 410.27 permits such services to be performed incident to other mental health practitioner services, CMS did not propose to expand the definition of "nonphysician practitioner" to include MFTs and MHCs. We request that CMS enact an amendment to this regulation to include these practitioners.

Merit-Based Incentive Payment System

The provisions for this payment system are set forth in 42 C.F.R. 414.1305 and 414.1380**. We respectfully request that the list of MIPS eligible clinicians be expanded to include MFTs and MHCs** as it does include other mental health practitioners. This would enable MFTs and MHCs to participate in the MIPS program.

Behavioral Health Specialties in Medicare Advantage (MA) Networks

CMS very recently adopted new regulations (Behavioral Health Specialties in Medicare Advantage (MA) Networks (42 C.F.R. 422.112 and 422.116) to allow Medicare Advantage Plans to incorporate new behavioral health provider types into their networks for the purposes of network adequacy and evaluation: clinical social workers, clinical psychologists, and prescribers of opioid use disorder medications.

CMS added behavioral health providers as a requirement for service standards for MA plans. The network evaluation includes base time, and distance standards for behavioral health providers as well as a minimum number of providers within each service area. Also, CMS added new behavioral health specialty types to the list of health services plans can use to satisfy the requirement that plans offer one or more telehealth services.

**MFTs and MHCs must be added to the list of providers that must be addressed by MA plans in terms of access to care and network adequacy in 42 C.F.R. 422.116. In addition, it must be clear that these practitioners are included in the behavioral health providers required to be provided in 42 C.F.R. 422.112.** In new rules effective June 5, 2023, licensed clinical social workers and clinical psychologists were added to these rules, and so these regulations will need to be brought up to date as MFTs and MHCs become eligible for Medicare payment. In the table listed in 42 C.F.R. 422.116, the standards for social workers can also be used for MFTs and MHCs.

**The Coalition strongly supports** CMS's proposals to integrate behavioral health practitioners into MA networks and the accompanying reimbursement of services for MA beneficiaries. This will expand access to mental health services for beneficiaries. With the direction from Congress to expand Medicare coverage for the services of MFTs and MHCs in Section 4121 of the CAA, **we ask that CMS apply the same network adequacy rules in its 2024 MPFS rule to MHCs and MFTs**. This action of strengthening network adequacy requirements would be consistent of CMS' goals in its broader strategy to improve behavioral health care access embodied in *CMS's Behavioral Health Strategy*.[5]

Programs for All-Inclusive Care for the Elderly ("PACE")

The PACE program requires PACE organizations to establish an interdisciplinary team. That team is comprised of a broad array of clinicians and healthcare professionals, including a "master's level social worker." We ask that PACE organizations be permitted the flexibility to fulfill that role with either a master's level social worker or an MFT or MHC. We ask CMS to amend 42 C.F.R. 460.102 accordingly. In addition. We ask that MFTs and MHCs be able to develop a discipline-specific assessment of the participant health and social status as an alternative to a social worker by amending 42 C.F.R. 460.104.

Home Health Services

We ask that CMS make clear that MFTs and MHCs may work professionally in a home health agency. To permit this, we request the following modifications to the home health agency Medicare regulations:

1. Clarify that MFTs and MHCs may supervise medical social services on behalf of a home health agency by amending 42 C.F.R. 484.75;
2. Specify that an MFT or MHC may be a clinic manager by amending 42 C.F.R. 484.115(c) and (m); and
3. Clarify that MFTs and MHCs may lawfully provide medical social services as set forth in 42 C.F.R. 409.45(c).

[5] See https://www.cms.gov/cms-behavioral-health-strategy

Comprehensive Outpatient Rehabilitation Facilities ("CORF")

We ask that CMS make clear that MFTs and MHCs may work professionally in a CORF by amending 42 C.F.R. 485.70 to encompass the qualifications of these practitioners.

End Stage Renal Disease ("ESRD") Facilities

We ask that CMS make clear that MFTs and MHCs may work professionally in an ESRD Facility by making the following additional regulatory amendments:

1. Sections 494.80 and 494.180—permitted services on the interdisciplinary care team (as an alternative to the social worker) and the performance of a patient assessment.
2. Section 494.90(a)(6)—implementation of needed psychosocial services.
3. Section 494.140—specification of MFT/MHC qualifications.
4. Section 405.2113—permitted service on ESRD Medical Review Board as an alternative to social workers.

**Rural Health Clinic ("RHC") and Federally Qualified Health Center ("FQHC") Rules**

MFTs/MHCs appear to be properly added to all known rules pertaining to RHCs/FQHCs. We support CMS's proposals to codify payment for MFTs and MHCs into the RHC and FQHC payment systems. We commend CMS for these proposals.

**Telehealth**

CMS has proposed to amend 42 C.F.R. 410.78 to specify that both MHCs and MFTs are included as distance site practitioners for purposes of furnishing telehealth services to Medicare enrollees. We strongly support the inclusion of MFTs and MHCs as distant site practitioners.

**Coding Update to Allow MFT and MHC Billing**

We would like to thank CMS for considering whether updates to certain Healthcare Common Procedure Coding System (HCPCS) codes are required in order to allow MFTs and MHCs to bill for services under these codes. In the MPFS, CMS is proposing to revise the code descriptor for HCPCS code G0323 so that MHCs and MFTs, as well as clinical social workers ("CSWs") and psychologists, will be able to bill for this important service. As CMS noted, **MFTs and MHCs are licensed and trained to provide these important care management services for behavioral health conditions. We strongly support this change.**

In this section, CMS welcomed comments regarding other HCPCS codes that may require updating to allow both MFTs and MHCs to properly bill for services described in the HCPCS code description. In addition to updating HCPCS code G0323 for utilization by MFTs and MHCs, **we urge CMS to update the code descriptors for all other HCPCS codes that are currently utilized by current Medicare behavioral health providers**. For example, MFTs and MHCs should be

allowed to bill for services described in HCPCS code G0409 pertaining to services directly relating to and/or furthering a patient's rehabilitation goals. **We encourage CMS to ensure that MFTs and MHCs are able to provide services and utilize applicable HCPCS codes** even if the code descriptors do not address the provider types eligible to bill for these services, such as HCPCs codes G0410 (group psychotherapy in a partial hospitalization setting) and the two new G-codes for psychotherapy for crisis services, GPFC1 and GPFC2.

**Health Behavioral Assessment and Intervention Services**

We would like to thank CMS for considering whether MHCs and MFTs should furnish and bill for Health Behavioral Assessment and Intervention ("HBAI") services. **CMS is proposing to allow MFTs, MHCs and CSWs to bill for HBAI services described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168, and any successor codes. We strongly support allowing MFTs, MHCs and CSWs to bill for these services**. CSWs, MFTs and MHCs have the education and training to address the psychosocial behaviors associated with physical health conditions. We applaud CMS for this important change.

**Fee Schedule**

CMS is proposing to codify in a new 42 C.F.R. 414.53 the payment amounts authorized for MFT and MHC services. Under Section 4121 of the CAA, 2023, the payment amount for MFT and MHC services is 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for clinical psychologist services by CMS. This payment formula is the same for CSWs. The new 42 C.F.R. 414.53 would codify this formula for CSWs, MHCs and MFTs. We believe that this new rule appears to conform to the requirements as stated in Section 4121 of the CAA, 2023.

Thank you again for all of CMS's efforts to bring about these important legal changes to expand access to behavioral health services by allowing Medicare payment for MFT and MHC services. We are thrilled to be working in this field during this exciting time. If we can provide any additional information to you for consideration of these additional changes, please contact the Coalition representatives for this letter: Roger Smith, Chief Advocacy Officer & General Counsel at the American Association for Marriage & Family Therapy, rsmith@aamft.org, Joel Miller of the National Board for Certified Counselors, joel.miller44@yahoo.com, Brian Banks, Chief Government Affairs & Public Policy Officer at the American Counseling Association, bbanks@counseling.org, and Dr. Beverly Smith, Interim Executive Director and CEO at the American Mental Health Counselors Association, AMHCACEO@gmail.com.

Sincerely,

American Association for Marriage and Family Therapy
American Counseling Association
American Mental Health Counselors Association
Association for Behavioral Health and Wellness

California Association of Marriage and Family Therapists
Centerstone
Center for Medicare Advocacy
Jewish Federations of North America
National Association for Rural Mental Health
National Association of County Behavioral Health and Developmental Disability Directors
National Board for Certified Counselors
National Council for Mental Wellbeing
National Council on Aging
Network of Jewish Human Services Agencies